West Virginia Offices of the Insurance Commissioner
QHP REVIEW REQUIREMENTS CHECKLIST

GROUP MARKET

REVIEW REQUIREMENTS	REFERENCE	COMMENTS
FORMS		
State Requirements ***All references are State of West Virginia statute and regulations, unless otherwise noted***		
General Requirements		
Fees	§33-6-34 §33-6-34	The fee for a Form Filing is $50 per Filing. The fee for a Rate Filing is $75 per Filing.
Submission	Informational Letter No 163 §33-3-7	All filings must be submitted through SERFF (System for Electronic Rate and Form Filing). Filing fees must be remitted via EFT (Electronic Funds Transfer) through SERFF. The company transacting insurance in this State must be licensed by the Insurance Commissioner and authorized to conduct the appropriate lines of business for the filing submitted 90 days prior to the start of Open Enrollment.
Certifications		
Readability	§33-29-5 (a)(1)	The Certification of Readability must show a Test Score of 40 or better according to the Flesch Score reading ease Method or by any other comparable method.
Compliance	33-16 114-10 114-26 114-28 114-29	Group Accident and Sickness policy forms must comply with Chapter 16 of the WV Code. The Required provisions are found in 33-16-3. Advertising – Department policy to require advertising filing on all Accident & Sickness products. Rate Filing Accident and Sickness Coordination of Benefits Temporo/Craniomandibular Disorders
Applications		
		The Application, when attached to the policy, and all its attachments become part of the Entire Contract. Statements are binding only if an application is attached. Only the applicant can alter statements on the application. This Division does not permit a box on the Application, **For Company Use Only**, because no changes are to be made to the Entire Contract after the application has been signed by the applicant. False statements may bar recovery.
General Characteristics		
Master Contract		Issuance of a master contract to the administrator of the group and individual certificates of insurance (outlines of coverage) to the members.
Coordination of Benefits		Coordination of benefits with other available coverages (such as workers compensation benefits)

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Legal Requirements		
Eligible Groups	§33-16-2	Group policies must come within any of the following classifications: (1) A policy issued to an employer, who shall be considered the policyholder, insuring at least two employees of the employer, for the benefit of persons other than the employer, and conforming to the following requirements: (A) If the premium is paid by the employer the group shall comprise all employees or all of any class or classes thereof determined by conditions pertaining to the employment; or (B) If the premium is paid by the employer and the employees jointly, or by the employees, there shall be no employee participation requirement. The term "employee" as used herein is considered to include the officers, managers and employees of the employer, the partners, if the employer is a partnership, the officers, managers and employees of subsidiary or affiliated corporations of a corporate employer, and the individual proprietors, partners and employees of individuals and firms, the business of which is controlled by the insured employer through stock ownership, contract or otherwise. The term "employer" as used herein may include any municipal or governmental corporation, unit, agency or department and the proper officers of any unincorporated municipality or department, as well as private individuals, partnerships and corporations.
Required Policy Provisions		Group policies must contain the following:
Entire Contract	§33-16-3(a)	A provision that the policy, application of the policyholder, and the individual applications submitted shall constitute the entire contract between the parties, and that all statements made by any applicant(s) shall be deemed representations and not warranties, and that no such statement shall void the insurance or reduce benefits thereunder unless contained in a written application.
Individual Certificates	§33-16-3(b)	A provision that the insurer will provide an individual certificate for each member of the group setting forth in substance the essential features of the coverage and to whom benefits are payable. If dependents are included, only one certificate need be issued for each family unit.
New Members	§33-16-3(c)	A provision that all new employees or members, in the groups or classes eligible for insurance, shall from time to time be added to such groups or classes eligible to obtain such insurance in accordance with the terms of the policy.
Prohibited Provisions	§33-16-3(d)	No provision relative to notice or proof of loss or the time for paying benefits or the time within which suit may be brought upon the policy shall be less favorable to the insured than would be permitted in the case of an individual policy by the provisions set forth in §§33-15-1 et seq.
Layoff Provision	§33-16-3(e)	A provision that all members shall be permitted to pay the premiums at the same group rate and receive the same coverages for a period not to exceed 18 months when they are involuntarily laid off from work.
Other Provisions	§33-16-3(f)	Further provisions as the commissioner shall promulgate by rule.
Mandatory Benefits		
Mental Health	45 CFR §156.115	Mental Illness Coverage – EHB covered under Mental health and substance use disorder services, including behavioral health treatment. Must be in parity with all other benefits.
Contraceptive Coverage	45 CFR §156.115	Contraceptive Coverage – EHB covered under Preventive and wellness services and chronic disease management (Women's Preventive Services). May file for waiver to provide stand alone coverage if exempted for religious reasons.
Autism Spectrum Disorders (Applies to policies delivered or renewed on or after January 1, 2012)	§33-16-3v	Must be in parity with other benefits.
Coordination of Benefits		
COB Contract Provision	§114-28-3.1	Appendix A of §114-28 contains a model COB provision.
Flexibility	§114-28-3.2	A group contract's COB provision does not have to use the words and format of the model. Changes may be made to fit the language and style of the rest of the group contract or to reflect the difference amount plans which provide services, which pay benefits for expenses incurred, and which indemnify. No other substantive changes are allowed.

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Cost Containment Provisions		
Mandatory Second Surgical Opinion		Company won't pay 100% of scheduled charges unless another physician's opinion is sought – emergencies excepted.
Pre-Admission Certification		1. Company approves the admission to the hospital (emergencies excepted).
Concurrent Review		A review of an insured's medical care while that care is being administered. The purpose of concurrent review is to assure that the required care is being provided.
Retrospective Review		Company reviews all charges by the hospital and the physician and looks for duplicate or unreasonable fees.
Ambulatory Outpatient Services		Deductible waived and at 100% if medically necessary.
Benefit Standards and Product Offerings		.
Essential Health Benefits	45 CFR §156.110 §156.115 §156.120 §156.122	☐ Covers the Essential Health Benefit Package. ☐Ambulatory patient services ☐Emergency services ☐Hospitalization ☐Maternity and newborn care ☐Mental health and substance use disorder services, including behavioral health treatment ☐Prescription drugs ☐Rehabilitative and habilitative services and devices ☐Laboratory services ☐Preventive and wellness services and chronic disease management ☐Pediatric services, including oral and vision care. ☐Offers coverage that is substantially equal to the benchmark plan. ☐Demonstrates actuarial equivalence of substituted benefits if substituting benefits. ☐Provides required number of drugs per category and class. ☐Provides habilitative benefits that are similar in scope, amount, and duration to benefits covered for habilitative services.
Informational Letter 186		In West Virginia, benchmark plan is Highmark Blue Cross Blue Shield West Virginia Super Blue Plus 2000 1000 Ded.; pediatric dental benefits are supplemented using the State's separate Children's Health Insurance Program (CHIP) program; pediatric vision benefits are supplemented using the Federal Employees Dental and Vision Insurance Program.

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Actuarial Value	45 CFR §156.135 §156.140 45 CFR §156.150 (for SADPs)	If health insurance, offers a plan that provides one of the following actuarial values (± 2%): ☐ Bronze plan (AV 60%) ☐ Silver plan (AV 70%) ☐ Gold plan (AV 80%) ☐ Platinum plan (AV 90%) ☐ Catastrophic plan FOR STAND-ALONE DENTAL ONLY Offers a plan that provides one of the following actuarial values(± 2%) : ☐ Low plan (AV 70%) ☐ High plan (AV 85%)
Catastrophic Plans	45 CFR §156.155	If offers a catastrophic plan, it is only offered to eligible individuals eligible to enroll in a catastrophic plan. Eligible individuals: ☐ Individuals that have not attained the age of 30 before the beginning of the plan year ☐ Individual has a certification in effect for any plan year exempt from the Shared Responsibility Payment by reason of lack of affordable coverage or hardship. ☐ If offered, catastrophic plans are offered only in the individual exchange and not in the SHOP. ☐ If offered, catastrophic plan complies with specific requirements for benefits.
Non-Discrimination	45 CFR §156.125 §156.225(b) §156.200(e)	☐ Does not have benefit designs that have the effect of discouraging the enrollment of individuals with significant health needs. ☐ Does not discriminate based on individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, other health conditions, race, color, national origin, disability, age, sex, gender identity, or sexual orientation. Passes outlier analysis of QHP cost sharing; information contained in the "explanations" and "exclusions" sections of the plans and benefits template does not include discriminatory practices or wording; issuers have attested to non-discrimination (per Chapter 1, Section 4i of CMS's "Letter to Issuers on Federally-Facilitated and State Partnership Exchanges" from March 1, 2013).
Mental Health Parity and Addiction Equity Act	45 CFR §156.115	Standard does NOT apply to stand-alone dental plans. ☐ Complies with the Mental Health Parity and Addiction Equity Act.
Meaningful Difference	N/A	Standard does NOT apply to stand-alone dental plans. ☐ Reflects meaningful difference across product offerings. Chapter 1, Section 4ii of CMS's "Letter to Issuers on Federally-Facilitated and State Partnership Exchanges" from March 1, 2013 clarifies CMS' intent related to this requirement.

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Rates		
Rating Factors	45 CFR §147.102 §156.255	Varies rates only based on: ☐ Geographic area ☐ Age (3 to 1) ☐ Tobacco use (1.5 to 1) ☐ Family composition: ☐ Individual ☐ Two-adult families ☐ One-adult family with child(ren) ☐ All other families Due to their excepted benefit status, stand-alone dental plans are not required to meet the rating rules of PHS Act section 2701(a) that underlie the QHP Rating Tables and Business Rules template, therefore sections 2.4.1 and 2.4.2 do not apply.
Other Rating Provisions	45 CFR §156.210(a)	☐ Sets rates for an entire benefit year, or for the SHOP, plan year.
Other Rating Provisions	45 CFR §156.255(b)	☐ Rates must be the same for a QHP offered inside and outside Exchange and without regard to whether the plan is offered through an Exchange or whether the plan is offered directly from the issuer or through an agent.
Other Rating Provisions	45 CFR §155.1020 §156.210(b)	☐ Submits rate information to the Exchange at least annually.
Rate Increases	45 CFR §155.1020 §156.210(c) §154.215	☐ Submits to the Exchange a justification for a rate increase prior to the implementation of the increase Submits Rate Filing Justification, including: • An CMS standardized Unified Rate Review data template (Part I) • Written description justifying the rate increase for increases subject to the review threshold (Part II) • Part III and the Redacted Actuarial Memorandum for public posting
Rate Increase Posting	45 CFR §155.1020 §156.210(c)	☐ Prominently posts the rate increase justification on issuer Web site prior to the implementation of the increase.
Accreditation Standards		
Accreditation	45 CFR §156.275(a)(1)	Standard does NOT apply to stand-alone dental plans. ☐ Accredited on the basis of local performance in the following categories by an accrediting entity recognized by CMS: ☐ Clinical quality measures, such as the HEDIS ☐ Patient experience ratings on a standardized CAHPS survey ☐ Consumer access ☐ Utilization management ☐ Quality assurance ☐ Provider credentialing ☐ Complaints and appeals ☐ Network adequacy and access ☐ Patient information programs
Accreditation Survey Results	45 CFR §156.275(a)(2)	☐ Authorizes the accrediting entity to release to the Exchange and CMS a copy of its most recent accreditation survey and survey-related information.

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Accreditation Timeline	45 CFR §155.1045 45 CFR §156.275(b)	☐ Accredited within the timeframe established by the Exchange. ☐ Maintains accreditation. During initial year of certification, issuer must have an existing commercial, Medicaid, or Exchange health plan accreditation in WV granted by an accrediting entity or must have scheduled, or plan to schedule, a review of QHP policies and procedures with the accrediting entity.
Network Adequacy and Provider Directory		•
General	45 CFR §156.230	☐ Complies with WV network adequacy laws and regulations in addition to the specific requirements listed below. ☐ Has a network for each plan with sufficient number and types of providers to ensure that all services are accessible without unreasonable delay. WV Informational Letter No. 112 provides standards related to distance/time and provider to enrollee ratios. Is accredited on network adequacy and attests to compliance or provides and access plan based on NAIC Model Act #74 Managed Care Plan Network Adequacy.
Essential Community Providers	45 CFR §156.230(a)(1) 45 CFR §156.235	☐ Has sufficient number and geographic distribution of Essential Community Providers, where available, to ensure reasonable and timely access to a broad range of such providers for low-income, medically underserved individuals in the service area. • Issuer achieves at least 30% ECP participation in network in the service area, agrees to offer contracts to at least one ECP of each type available by county, and agrees to offer contracts to all available Indian providers; or • Issuer fails to achieve either standard but submits a satisfactory narrative justification as part of its submission.
Mental Health and Substance Abuse Providers	45 CFR §156.230	☐ Network must include providers that specialize in mental health and substance abuse services. Issuers establish a standard to assure that the QHP network complies with the Federal standard; a copy of this standard is included in application and issuer certifies that the network meets the standard. Standard does NOT apply to stand-alone dental plans.
Provider Directory	45 CFR §156.230(b)	Makes its provider directory available: ☐ To the Exchange for publication online in accordance with guidance from the Exchange ☐ To potential enrollees in hard copy upon request. ☐ Provider directory identifies providers that are not accepting new patients. Provides network names, IDs, and URL in a Network Template.
Marketing, Applications, and Notices		
WV Laws	45 CFR §156.225(a)	☐ Complies with all WV marketing laws & regulations. ☐ Certificate of Readability provided WV Legislative Rules Title 114 Series 10; WV 33-29-5
Non-discrimination	45 CFR §156.225(b)	☐ Marketing practices do not discourage the enrollment of individuals with significant health needs.

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Readability/Accessibility	45 CFR §155.230(b)	Provides applications and notices to applicants and enrollees all applications and other material: ☐ In plain language ☐ In a manner that is accessible and timely to: ☐ Individuals living with disabilities ☐ Individuals with limited English proficiency through the provision of language services at no cost to the individual.
Quality Standards		
Quality	45 CFR §156.200 (b)(5) ACA § 1311(c)(1), 1311(c)(3), 1311(c)(4), and 1311(g)	☐ Attests to comply with future Federal rule-making related to 45 CFR §156.200(b)(5).
Issuers will be required to attest to the Federal requirements included in the following sections.		
Transparency Requirements		
Coverage Transparency	45 CFR §155.1040 45 CFR §156.220	Makes available to the public, Exchange, CMS, and the WV Insurance Commissioner in an accurate and timely manner, and in plain language: ☐ Claims payment policies and practices ☐ Periodic financial disclosures ☐ Data on enrollment ☐ Data on disenrollment ☐ Data on the number of claims that are denied ☐ Data on rating practices ☐ Information on cost-sharing and payments for out-of network coverage ☐ Information on enrollee rights under title I of the Affordable Care Act (includes insurance market reforms and Patient's Bill of Rights)
Enrollee Cost-Sharing	45 CFR § 156.220(d)	☐ Makes available the amount of enrollee cost-sharing for a specific item or service by a participating provider in a timely manner upon the request of the individual. Makes available such information through: ☐ Internet website ☐ Other means for individuals without access to the Internet
Appeals Notices	45 CFR §147.136(e)	☐ Provides required notices on internal and external appeals in a culturally and linguistically appropriate manner.
Enrollment Periods		
Annual	45 CFR §155.410(b)	☐ Provides an initial open enrollment period
Special	45 CFR §155.420	☐ Provides special enrollment periods for qualified enrollees. ☐ Provides notice to individuals eligible to enroll during a special enrollment period.

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Enrollment Process for Qualified Individuals		
Enrollment	45 CFR §156.265 (b)(1) 45 CFR §156.265 (b)(2) 45 CFR §156.265 (c) 45 CFR §156.265 (d) 45 CFR §156.265 (e) 45 CFR §156.265 (f)45 CFR §156.400 (d) 45 CFR §156.265 (g)	☐ Enrolls a qualified individual when Exchange notifies the issuer that the individual is a qualified individual and transmits information to the issuer. ☐ If an applicant initiates enrollment directly with the issuer for enrollment through the Exchange, the issuer either: ☐ Directs the individual to file an application with the Exchange ☐ Ensures that the individual received an eligibility determination for coverage through the Exchange via the Exchange Internet website. ☐ Accepts enrollment information consistent with the privacy and security requirements established by the Exchange. ☐ Uses the premium payment process established by the Exchange. ☐ Provides new enrollees an enrollment information package that is compliant with accessibility and readability standards. ☐ Reconciles enrollment files with CMS and the Exchange no less than once a month. ☐ Acknowledges receipt of enrollment information transmitted from the Exchange in accordance with Exchange standards.
Termination of Coverage of Qualified Individuals		
Termination Allowances	45 CFR §155.430(b) 45 CFR §156.270	Terminates coverage only if: ☐ Enrollee is no longer eligible for coverage through the Exchange ☐ Enrollee's coverage is rescinded ☐ QHP terminates or is decertified ☐ Enrollee switches coverage: ☐ During an annual open enrollment period ☐ Special enrollment period ☐ Obtains other minimum essential coverage ☐ For non-payment of premium only if: ☐ Applies termination policy for non-payment of premium uniformly to enrollees in similar circumstances ☐ Enrollee is delinquent on premium payment ☐ Provides the enrollee with notice of such payment delinquency ☐ Provides a grace period of at least three consecutive months if an enrollee is receiving advance payments of the premium tax credit and has previously paid at least one month's premium
Notice	45 CFR §155.430 (d)45 CFR §156.270 (b)	☐ Provides reasonable notice of termination of coverage to the Exchange and enrollee (this includes effective date of termination).
Records	45 CFR §155.430(c) 45 CFR §156.270(h)	☐ Maintains records of terminations of coverage for auditing.

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SHOP-Specific Requirements	45 CFR §156.285	
		☐ Accepts payment from the SHOP on behalf of a qualified employer or employee. ☐ Adheres to the SHOP timeline for rate setting. ☐ Charges the same contact rate for a plan year.
		☐ Adheres to the SHOP enrollment timeline and process. ☐ Receives enrollment information electronically. ☐ Provides new enrollees with an enrollment information package. ☐ Reconciles enrollment files with the SHOP at least monthly. ☐ Acknowledges receipt of enrollment information in accordance with SHOP standards. ☐ Enrolls all qualified employees consistent with the employer's plan year. ☐ Enrolls a qualified employee in accordance with the qualified employer's annual open enrollment period. ☐ Provides special enrollment periods. ☐ Provides an enrollment period for an employee who becomes a qualified employee outside of the initial or annual open enrollment period. ☐ Adheres to effective dates of coverage.
		☐ Complies with requirements with respect to termination of employees.
		☐ If a qualified employer withdraws from the SHOP, terminates coverage for all enrollees of the withdrawing employer.
Recertification and Decertification		
Recertification	45 CFR §156.290	If elects not to seek recertification with the FFE: ☐ Notifies the FFE of its decision prior to the beginning of the recertification process and procedures adopted by the FFE ☐ Fulfills its obligation to cover benefits for each enrollee through the end of the plan or benefit year ☐ Fulfills data reporting obligations from the last plan or benefit year of the certification ☐ Provides written notice to enrollees ☐ Terminates coverage for enrollees in the QHP.
Decertification	45 CFR §156.290	☐ If decertified by the FFE, terminates coverage for enrollees only after: ☐ The FFE has made notification ☐ Enrollees have an opportunity to enroll in other coverage
Other Substantive and Reporting Requirements		
General Compliance	45 CFR §156.200(b)(2)	☐ Complies with all Exchange processes, procedures, requirements.
User Fee	45 CFR §156.200(b)(6)	☐ Pays the Exchange user fee.
Risk Adjustment	45 CFR §156.200(b)(7)	☐ Complies with risk adjustment program.
Non-Discrimination	45 CFR §156.200(e)	☐ Does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, or sexual orientation.
Consumer Interest	45 CFR §155.1000(c)(2)	☐ Is in the interest of qualified individuals.
Claims, Appeals, and External Review	45 CFR §147.136	☐ Complies with internal claims and appeals and external review process.
Direct Primary Medical Home	45 CFR §156.245	If provides coverage through a direct primary care medical home: ☐ Medical home meets criteria established by CMS ☐ Issuer meets all requirements otherwise required ☐ Issuer coordinates the services covered by the direct primary care medical home

Data-Sharing		☐ Collects and transmits data to and from Exchanges, CMS, Treasury, and reinsurance entities. ☐ Provides a description of system infrastructure's capacity to securely interface with these entities for data transfers, including enrollment, reconciliation, claims encounter data, and reports.
Prescription Drug Distribution and Cost Reporting	45 CFR §156.295	☐ Reports to U.S. DCMS on prescription drug distribution and cost the following information (paid by PBM or issuer): ☐ Percentage of all prescriptions that were provided through retail pharmacies compared to mail order pharmacies ☐ Percentage of prescriptions for which a generic drug was available and dispensed compared to all drugs dispensed, broken down by pharmacy type: ☐ Independent pharmacy ☐ Supermarket pharmacy ☐ Mass merchandiser pharmacy ☐ Aggregate amount and type of rebates, discounts, or price concessions that the issuer or its contracted PBM negotiates that are: ☐ Attributable to patient utilization ☐ Passed through to the issuer ☐ Total number of prescriptions that were dispensed. ☐ Aggregate amount of the difference between the amount the issuer pays its contracted PBM and the amounts that the PBM pays retail pharmacies, and mail order pharmacies.
State Mandates and Coverages		
Preventative checkups	§5-16-7	Coverages and benefits for x-ray and laboratory services in connection with mammograms when medically appropriate and consistent with current guidelines from the United States Preventive Services Task Force; pap smears, either conventional or liquid-based cytology, whichever is medically appropriate and consistent with the current guidelines from either the United States Preventive Services Task Force or The American College of Obstetricians and Gynecologists; and a test for the human papilloma virus (HPV) when medically appropriate and consistent with current guidelines from either the United States Preventive Services Task Force or the American College of Obstetricians and Gynecologists, when performed for cancer screening or diagnostic services on a woman age 18 or over Annual checkups for prostate cancer in men age 50 and over Annual screening for kidney disease as determined to be medically necessary by a physician using any combination of blood pressure testing, urine albumin or urine protein testing, and serum creatinine testing as recommended by the National Kidney Foundation
Maternity	§5-16-7	For plans that include maternity benefits: coverage for inpatient care in a duly licensed healthcare facility for a mother and her newly born infant for the length of time which the attending physician considers medically necessary for the mother or her newly born child. No plan may deny payment for a mother or her newborn child prior to 48 hours following a vaginal delivery or prior to 96 hours following a caesarean section delivery if the attending physician considers discharge medically inappropriate For plans which provide coverages for post-delivery care to a mother and her newly born child in the home: coverage for inpatient care following childbirth as provided in §5-16-7(a)(4) of this code if inpatient care is determined to be medically necessary by the attending physician. These plans may include, among other things, medicines, medical equipment, prosthetic appliances, and any other inpatient and outpatient services and expenses considered appropriate and desirable by the agency
Mental Disabilities	§5-16-7	Seven years of age or younger or is developmentally disabled and is an individual for whom a successful result cannot be expected from dental care provided under local anesthesia because of a physical, intellectual, or other medically compromising condition of the individual and for whom a superior result can be expected from dental care provided under general anesthesia.

		A child who is 12 years of age or younger with documented phobias or with documented mental illness and with dental needs of such magnitude that treatment should not be delayed or deferred and for whom lack of treatment can be expected to result in infection, loss of teeth, or other increased oral or dental morbidity and for whom a successful result cannot be expected from dental care provided under local anesthesia because of such condition and for whom a superior result can be expected from dental care provided under general anesthesia Coverage for diagnosis, evaluation, and treatment of autism spectrum disorder in individuals ages 18 months to 18 years. To be eligible for coverage and benefits under this subdivision, the individual must be diagnosed with autism spectrum disorder at age eight or younger. Such plan shall provide coverage for treatments that are medically necessary and ordered or prescribed by a licensed physician or licensed psychologist and in accordance with a treatment plan developed from a comprehensive evaluation by a certified behavior analyst for an individual diagnosed with autism spectrum disorder.
Insurance	§16-54-8	At a minimum, an insurance provider who offers an insurance product in this state, the Bureau for Medical Services, and the Public Employees Insurance Agency shall provide coverage for 20 visits per event of physical therapy, occupational therapy, osteopathic manipulation, a chronic pain management program, and chiropractic services, as defined in §30-16-3 of this code, when ordered by a health care practitioner to treat conditions that cause chronic pain. **Any deductible, coinsurance, or co-pay required for any of these services may not be greater than the deductible, coinsurance, or co-pay required for a primary care visit**
Insurance Commissioner Rule	§33-16-3bb	The Insurance Commissioner: • shall propose rules in accordance with the provisions of §29A-3-1 et seq. of this code to develop a procedure for an expedited review of an adverse decision as set forth in this section. The Legislature finds that for the purposes of §20A-3-15 of this code, an emergency exists requiring the promulgation of an emergency rule to respond to the growing need in our state for substance abuse treatment. • shall develop a medical necessity review shall use an evidence-based and peer-reviewed clinical review tool. Rules shall ensure that the tool is based on appropriate evidence-based criteria that has been peer reviewed. The Insurance Commissioner shall propose rules for legislative approval in accordance with the provisions of §29A-3-1 et seq. of this code to develop the tool. • a group accident and sickness policy that provides hospital or medical expense benefits and is delivered, issued, executed, or renewed in this state, or approved for issuance or renewal by the Insurance Commissioner, on or after January 1, 2019, shall provide benefits for inpatient and outpatient treatment of substance use disorder at in-network facilities at the same level as other medical services offered by the group accident and sickness policy. • a health benefit plan offered by a health plan issuer that provides hospital or medical expense benefits and is delivered, issued, executed, or renewed in this state, or approved for issuance or renewal by the Insurance Commissioner, on or after January 1, 2019, shall provide benefits for inpatient and outpatient treatment of substance use disorder at in-network facilities at the same level as other medical services offered by the health benefit plan. • a health benefit plan offered by a health plan issuer that provides hospital or medical expense benefits and is delivered, issued, executed, or renewed in this state, or approved for issuance or renewal by the Insurance Commissioner, on or after January 1, 2019, shall provide benefits for inpatient and outpatient treatment of substance use disorder at in-network facilities at the same level as other medical services offered by the health benefit plan offered by a health plan issuer.

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Discipline	§30-3-14	Nothing in this article shall prohibit disciplinary action or criminal prosecution of a prescriber for: o Failing to maintain complete, accurate, and current records documenting the physical examination and medical history of the patient, the basis for the clinical diagnosis of the patient, and the treatment plan for the patient; o Writing a false or fictitious prescription for a controlled substance scheduled in §60A-2-201 et seq. of this code; or o Prescribing, administering, or dispensing a controlled substance in violation of the provisions of the federal Comprehensive Drug Abuse Prevention and Control Act of 1970, 21 U.S.C. §§801, et seq. or chapter §60A-1-101 et seq. of this code; o Diverting controlled substances prescribed for a patient to the physician's own personal use or o Abnormal or unusual prescribing or dispensing patterns, or both as identified by the Controlled Substance Monitoring Program set forth in §60A-9-1 et seq. of this code. These prescribing and dispensing patterns may be discovered in the report filed with the appropriate board as required by section §60A-9-1 et seq. of this code. Nothing in this article shall prohibit disciplinary action or criminal prosecution of a nurse or pharmacist for: o Administering or dispensing a controlled substance in violation of the provisions of the federal Comprehensive Drug Abuse Prevention and Control Act of 1970, 21 U.S.C. §§801, et seq. or §60A-1-101 of this code; or o Diverting controlled substances prescribed for a patient to the nurse's or pharmacist's own personal use. Upon receipt of the quarterly report set forth in §60A-9-1 et seq. of this code, the licensing board shall notify the prescriber that he or she has been identified as a potentially unusual or abnormal prescriber. The board may take appropriate action, including, but not limited to, an investigation or disciplinary action based upon the findings provided in the report. A licensing board may upon receipt of credible and reliable information independent of the quarterly report as set forth in §60A-9-1 et seq. of this code initiate an investigation into any alleged abnormal prescribing or dispensing practices of a licensee. The licensing boards and prescribers shall have all rights and responsibilities in their practice acts
Coverage for amino-based formulas	§33-15-4p	A policy, plan, or contract that is issued or renewed on or after January 1, 2019, and that is subject to this article shall provide coverage, through the age of 20, for amino acid-based formula for the treatment of severe protein-allergic conditions or impaired absorption of nutrients caused by disorders affecting the absorptive surface, function, length, and motility of the gastrointestinal tract. This includes the following conditions, if diagnosed as related to the disorder by a physician licensed to practice in this state pursuant to either §30-3-1 *et seq*. or §30-14-1 *et seq*. of this code: o Immunoglobulin E and Nonimmunoglobulin E-medicated allergies to multiple food proteins; o Severe food protein-induced enterocolitis syndrome; o Eosinophilic disorders as evidenced by the results of a biopsy; and o Impaired absorption of nutrients caused by disorders affecting the absorptive surface, function, length, and motility of the gastrointestinal tract (short bowel). The coverage required by §33-24-7q(a) of this code shall include medical foods for home use for which a physician has issued a prescription and has declared them to be medically necessary, regardless of methodology of delivery. For purposes of this section, "medically necessary foods" or "medical foods" shall mean prescription amino acid-based elemental formulas obtained through a pharmacy: *Provided*, that these foods are specifically designated and manufactured for the treatment of severe allergic conditions or short bowel. The provisions of this section shall not apply to persons with an intolerance for lactose or soy

Lyme disease	§33-15-4p	Lyme Disease is to be covered by all health insurance policies. Coverage for Lyme Disease patients includes long-term antibiotic therapy when determined medically necessary by a licensed physician after evaluation. Insurers that provide insurance for an issue of accident of sickness on or after January 1, 2019, shall make benefits available to all on an expense-incurred basis. Individuals and groups or contracts that have security or protection against a loss or other financial burdens that are issued by nonprofit corporations shall provide coverage for long-term antibiotic therapy for Lyme Disease.